RECORD OF AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MADISON STATE HOSPITAL
Indiana Family & Social Services Administration
State Form 4116 (R6/4-04)

SECTION A: Psychotherapy Notes

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it must *not be* used as an authorization for any other type of protected health information.

SECTION B: The Patient (or the Patient's Legal Representative) Confirming the Authorization

I authorize the use and/or disclosure of my protected health information as described in Section C below**.** I understand this authorization is made to confirm my direction.

I understand that:

- this authorization is voluntary (you may refuse to sign);
- my health care and payment for my health care will not be affected if I do not sign this form;
- if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.
- information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and no longer protected.

Name: _____ Hospital # *(if known)* _____

Address: _____

Telephone: _____ Social Security # : _____

SECTION C: The Use and/or Disclosure Being Authorized

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed: *(If this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization.)*

☐ Discharge Summary
☐ Admission Note
☐ Physical Examination
☐ Psychiatric Assessment
☐ Psychological Evaluation
☐ Treatment Plan Evaluation

Other: _____

_____

_____

Entities Authorized to Receive, Use or Disclose: Name or specifically identify the persons or organizations *(or the classes of persons and/or organizations)*, including Madison State Hospital, who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above:

I authorize information to be: *(check one or both)* ☐ released **TO** Madison State Hospital from

_____ _____
(Name/Title/Organization) (Address)
(Receipt of protected health information is limited to one health care provider per authorization form.)

☐ released **FROM** Madison State Hospital to

_____ _____
(Name/Title/Organization) (Address)

_____ _____
(Name/Title/Organization) (Address)

_____ _____
(Name/Title/Organization) (Address)

SECTION D: Purpose

The information is being used/disclosed for the following purpose: _____

_____

_____

SECTION E: Expiration and Revocation

Expiration: This authorization will expire *(complete one)*:

☐ On _____/_____/_____ (DD/MM/YR).

☐ On occurrence of the following event:
(which must relate to the patient or to the purpose of the use and/or disclosure being authorized)

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Madison State Hospital Privacy Officer. I understand that revocation of this authorization will *not* affect any action taken by Madison State Hospital in reliance on this authorization before my written notice of revocation was received. Written revocation should be sent to: Madison State Hospital Privacy Officer; 711 Green Road, Madison, IN 47250; (812-265-2611).

SECTION F: Alcohol & Drug Abuse Information

I understand that this authorization may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, or AID's-related information may be released.

SECTION G: Facsimile Communication

I understand that this information may be communicated by facsimile.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Madison State Hospital. I understand that, by signing this form, I am confirming my authorization that Madison State Hospital may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a patient's legal representative on behalf of the patient, complete the following:

Legal Representative's Name: _____

Relationship to Patient: _____

42 CFR PART 2:

This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.